STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155149	B. WIN	G		10/18/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HARCOU	JRT TERRACE NUF	RSING AND REHABILITATION			ARCOURT RD APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0000							
	This visit was for and State Licer	or the Recertification nsure Survey.	F00	00			
	Survey dates: 18, 2012	October 15, 16, 17 &					
	Facility number Provider number AIM number: 1	er: 155149					
	Survey team: Christi Davidso Connie Landma Diana Zgonc, F Lora Brettnach Census bed typ SNF: 2	an, RN RN er, RN					
	SNF/NF: 81 Total: 83						
	Census payor f Medicare: 10 Medicaid: 65 Other: 8 Total: 83	type:					
		cies reflect state n accordance with 410					
	Quality review Williams, RN	10/23/12 by Suzanne					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING X3) DATE SURVEY COMPLETED			
		155149	B. WING		10/18/2012
	NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			ADDRESS, CITY, STATE, ZIP CODE IARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=G	483.10(b)(11) NOTIFY OF CHA (INJURY/DECLI A facility must in resident; consult physician; and if legal representa member when the resident which the potential for intervention; a si resident's physicistatus (i.e., a defor psychosocial threatening concomplications); a significantly (i.e. existing form of the consequences, of treatment); or discharge the respecified in §483. The facility must resident and, if k representative of when there is a commate assign §483.15(e)(2); of under Federal of specified in para. The facility must update the addressed in the sident and t	ANGES NE/ROOM, ETC) Inmediately inform the with the resident's known, notify the resident's tive or an interested family here is an accident involving the results in injury and has requiring physician gnificant change in the ral, mental, or psychosocial herioration in health, mental, status in either life litions or clinical a need to alter treatment a need to discontinue an reatment due to adverse for to commence a new form a decision to transfer or sident from the facility as 3.12(a). also promptly notify the nown, the resident's legal or interested family member change in room or ment as specified in or a change in resident rights or State law or regulations as graph (b)(1) of this section.			
	Based on inter review, the fact family and/or the residents review	rview and record cility failed to notify the he physician for 1 of 36	F0157	The creation and submission of this Plan of Correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation	ot e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y7WM11

Facility ID: 000070

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPL	ETED
		155149	B. WIN			10/18/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ARCOURT RD		
HARCOL	IRT TERRACE NU	RSING AND REHABILITATION			APOLIS, IN 46260		
	·				74 OLIO, IIV 40200		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·		DATE
		nge. This change had			regulation.This provider respectfully requests that the		
	•	r requiring physician			2567L, Plan of Correction, be		
	intervention wh	nich could have			considered the Letter of Credil	ble	
	prevented his	death (Resident #116).			Allegation and respectully		
					requests an IDR on or after		
	Findings includ	le:			11-4-12.F157 Notify of Change	es	
					(Injury/Decline/Room, etc)It is	the	
	Resident #116	's record was reviewed			practice of this facility to		
		at 2:22 P.M. Resident			immediately inform resident;		
		ted to this facility on			consult with the resident's physician; and it known the		
	6/13/2012. Res	•			resident's legal representative	or	
					an interested family member	O.	
	•	uded, but were not			when there is an accident		
		etes, uncomplicated,			infolving the resident which		
	• •	erebral vascular			results in injury and has the		
	disease(stroke), hemiplegia,			potential for requiring physicia		
	depression, his	story of acute renal			intervnetion; a significant char		
	failure, history	of prostate cancer			in the resident's physical, men or psychosocial status; a need		
	insitu, history o	of metabolic acidosis,			alter treatment significantly; or		
	dysphagia, and	d hypertension.			decision to transfer or discharge		
		,,			the resident from the facility as		
	Resident #116	had been in another			specified in 483.12(a)1. What		
		ollowing a stroke which			corrective action(s) will be		
	· ·	y of 2012. This stroke			accomplished for those reside		
		int side of his body.			found to have been affected by the deficient practice?Residen	•	
	۷	,			#116's physician was notified		
		cility he developed			change in level of consciousne		
		and was sent to an			and change in condition.	300	
		pital due to a mental			Resident #116 no longer resid	es	
		and was treated for			at the facility.2. How will you		
		osis and acute renal			identify other residents having		
	failure seconda	ary to volume depletion.			potential to be affected by the	se	
	The hospital's	transfer report dated			same deficient practices and		
	6/13/2012 indic	cated both issues were			what corrective action will be taken?All residents have the		
	resolved over t	the course of the			potential to be affected. All		
		nd Resident #116 was			licensed nurses were inservice	ed	
		Harcourt Terrace in			by the Clinical Nurse Specialis		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155149				10/18/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ARCOURT RD		
НАВСОІ	IRT TERPACE NIII	IRSING AND REHABILITATION			ARCOURT RD IAPOLIS, IN 46260		
					JEIO, III 70200		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	EACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG			+	TAG			DATE
		on on 6/13/2012 to			October 31, 2012, regarding physician notification, change	of	
		oilitation from the			condition assessment, utilizin		
	stroke.				SBAR prior to sending reside	-	
					to the hospital, utilizing vital s		
	A nurses note	dated 6/13/2012			assessment methods, and	J	
		dent #116 was alert			utilizing facility electronic med	lical	
		out hard to understand			record reports to give shift to		
	· ·	phagia, A nursing note			report.3. What measures will		
					put into place or what system		
		12 indicated Resident			changes you will make to ens		
		t to self only. A nurse's			that the deficient practice doe	S	
	noted dated 7/	4/2012 indicated			not recur?Charge Nurses will		
	Resident #116	was alert to self and			notify the physician/family of a changes in condition 24 hours		
	environment, a	ambulated by			day/7 days per week. All licer		
		as able to make needs			nurses were inserviced by the		
	1	as in a happy mood that			Clinical Nurse Specialist on	-	
	shift.	as a happy mood that			October 31, 2012, regarding		
	Jillit.				physician notification, change	of	
	A 00 00 01 5 1 5	stad 6/20/2042 :td			condition assessment, utilizin	-	
	•	ated 6/20/2012 indicated			SBAR prior to sending reside		
		was a full code, had			to the hospital, utilizing vital s	ign	
	support from fa	amily, and his wife			assessment methods, and	l: I	
	visited almost	daily since admission.			utilizing facility electronic med		
	Discharge plai	ns were for him to			record reports to give shift to report DNS/Designee will mo		
		rith his wife. Resident			physician orders for physician		
		sen to have life			family notification.		
		asures with approaches			DNS/Designee will monitor th	е	
		o call the emergency			facility electronic medical reco		
		9			facility activity report to ensure	e all	
		needed and notify MD			resident change of condition a		
	and family of d	condition changes.			potential change of conditions		
					reported to physician and fam		
	A nurse's note	dated 7/7/2012 at 2:15			including vital signs out of ran	•	
	P.M. indicated	, "Resident is less			Licensed staff not adhering to	1	
	responsive that	an normal. BP (blood			policy will receive education, disciplinary action up to and		
		62 P (pulse) 64 02 sat			including termination.4. How	will	
		ation) on RA (room air)			the corrective action(s) be		
		spirations) 26. No signs			monitored to ensure the defic	ient	
	I oo /o i koop (i o	spirations, Lo. 140 signs	ı		i		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE ((X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155149	B. WING		10/18/2012
NAME OF P	PROVIDER OR SUPPLIEF	\ \		ADDRESS, CITY, STATE, ZIP CODE	
ПУБССТ		DOING AND DELIABILITATION		HARCOURT RD	
		RSING AND REHABILITATION		NAPOLIS, IN 46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·	TAG	practice will not recur, ie, wha	
		Opens eyes when nae Answering service for		quality assurance program wi	
		alled at this time.		put into place?The physician	
	,	call from (Nurse		notification CQI tool will be us	
	Practitioner [NI	•		weekly x 4, bimonthly x 2, and quarterly thereafter, for at least	
	i raciiionei [M	j nameu).		months. Action plans will be	51.0
	A telenhone or	der dated 7/7/12 at		adjusted until 95% compliance	
	·	ated the NP gave		achieved.5. Date of compliance	ce
		Resident #116's vitals		11-4-12	
		for 24 hours. This order			
		roblem was a change			
	•	f conscience) and the			
	,	as the above order.			
	The next two n	ursing notes were			
	recorded as lat	e entries on 7/8/2012			
	at 2:46 P.M. ar	nd 2:53 P.M. The late			
	entry recorded	on 7/8/2012 at 2:46			
	P.M. for 7/7/20	12 at 3:34 P.M.			
	indicated, "Res	sident is responding to			
	voice and touc	h. He is pulling hand			
	and arm away.	The late entry dated			
		3 P.M. for 7/7/2012 at			
		ated, "Resident has			
	•	Irink, he is a little more			
	•	this time VS (vitals) are			
	WNL (within no	•			
	· ·	labored, resting at this			
	time."				
	The	ual in alia a ka alia			
		rd indicated on			
		9 P.M. Resident			
		ere: blood pressure			
	•	72, respirations 20, and			
	oxygen saturat	ions were 96%.			

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Event ID: Y7WM11

Facility ID: 000070

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155149	B. WING		10/18/2012	
				ADDRESS, CITY, STATE, ZIP CODE	ı	
NAME OF F	PROVIDER OR SUPPLIEI	K		IARCOURT RD		
		RSING AND REHABILITATION	INDIAN	IAPOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	at 12:00 A.M. is asleep with HC elevated. no sisymptoms) of control of the contro	ng note dated 7/8/2012 Indicated, "Res in bed DB (head of bed) Is/sx (signs or distress/discomfort low with landing mat at ght in reach, no tion noted. spoke with inform her of res status. Is not eating food during				
	7/8/2012 at 12 #116's vitals w 78/60, respirat saturation was was document vitals documer	:15 A.M., Resident vere: blood pressure ions 20, no oxygen documented, no pulse red. According to the at, the facility utilizes a ranges for blood				
	2:15 A.M. puls was 362 mg/dl 97.7. Oxygen	documented were at se was 48, blood sugar l, and temperature was saturation or blood not documented.				
	7/8/2012 at 3:0 indicated, "res elevated. CN/Assistant) repo	e's note was dated 08 A.M. This note in bed with HOB A (Certified Nursing orted res breathing with r went in to assess res				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155149	B. WING			10/18/	2012
NAME OF P	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
ПУВСОІ	IDT TEDDACE NI II	RSING AND REHABILITATION			ARCOURT RD APOLIS, IN 46260		
					AFOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
IAG		ations 22-24 per min.		IAG			DATE
	. , .	2 mg/DL, writer put res					
		oxygen per nursing					
	measures. MD						
		call. upon awaiting					
	_	MD writer unable to					
		on no chest movement					
	•	bed et placed on hard					
	surface CPR in	·					
		staff 911 called. after					
	EMT (Emerger						
	` `	rrives et continued					
	,	ed on-call manager to					
		atus. family/wife					
		ly states they are on					
		ity spoke with (NP					
	named)/(Dr. na	imed) on call and order					
	to release body	to mortuary of choice,					
	death certificat	e completed et given to					
	mortician. Dr f	rom (hospital named)					
	to sign off on ti	me of death per EMT					
	personnel."						
		view on 10/17/2012 at					
		facility's corporate					
	clinical nurse c	onsultant was asked to					
	•	ident's entire chart					
		r orders, doctor					
		e plans, hot charting,					
	event charting,						
	documents, pro	•					
		of vitals, and any					
	_	arding care given to					
	Resident #116						
	abnormal blood	d pressure was noted					

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Event ID: Y7WM11

Facility ID: 000070

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ((X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155149	A. BUILDING	00	COMPLETED 10/18/2012
		100170	B. WING	CADDRESS CITY STATE ZID CODE	10/10/2012
NAME OF F	PROVIDER OR SUPPLIER			FADDRESS, CITY, STATE, ZIP CODE HARCOURT RD	
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		NAPOLIS, IN 46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
TAG		7:49 P.M. through 2:15	IAU		DATE
		pulse was documented			
		r minute prior to his			
	cardiac arrest.	i illinato prior to filo			
	During an inter	view on 10/17/2012 at			
	_	facility's corporate			
		onsultant indicated the			
	doctor or family	had not been notified			
	of the abnorma	Il blood pressure.			
	_	view on 10/18/2012 at			
	· ·	NP, who was notified			
	of Resident #1				
		(LOC) change and			
	_	to monitor vitals every			
		hours, was questioned			
		ve intervened if she			
		ed of Resident #116's dropping from 110/72			
	•	78/60 at 12:15 A.M.			
		he was awake and			
	•	other symptoms, I			
	_	lered stat labs. It just			
		hat they told me. If he			
	•	d have just sent him to			
		She indicated she did			
	•	the call or what they			
	told her.	-			
	During an inter	view on 10/18/2012 at			
	_	Executive Director			
	· · · · · · · · · · · · · · · · · · ·	irector of Nursing			
	` '	d the information			
	` ′	esident #116's death.			

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Event ID: Y7WM11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155149	B. WIN			10/18/	/2012
NAME OF I	PROVIDER OR SUPPLIEI	· R	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ARCOURT RD		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION		INDIAN.	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		cated the doctor should					
		ified of the abnormal					
		e. The ED indicated					
		aff who documented on					
		t the time in question					
	· ·	oyed, therefore not					
	available for in	iterviews.					
	Δ current facili	ty policy provided by					
		rurse consultant on					
		P.M. indicated: It is					
		is facility that all					
		sident condition will be					
	_	I to the physician and					
		ible party, and that					
		nely and effective					
		ccursAcute Medical					
		udden or serious					
		sident's condition					
	_	a marked change in					
	_	ntal behavior will be					
		I to the physician with a					
		sician visit promptly					
		are evaluation. the					
		in charge will notify the					
		he responsible party					
	1	that there has been a					
		resident's condition and					
	_	being taken. All					
		s/interventions will be					
	_	the medical record as					
		ole after resident needs					
	have been me						
	3.1-5(a)						

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Event ID: Y7WM11

Facility ID: 000070

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 10/1	TE SURVEY TPLETED 18/2012	
		RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y7WM11

Facility ID: 000070

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING O COMPL	ETED
155149 B. WING 10/18/	2012
STREET ADDRESS. CITY. STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 8181 HARCOURT RD	
HARCOURT TERRACE NURSING AND REHABILITATION INDIANAPOLIS, IN 46260	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	COMPLETION
TAG REGULATOR OR ESC IDENTIFY THOUSAND TO TAG	DATE
F0309 SS=G #83.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to thoroughly assess, treat, and ensure care was provided for a resident with a significant change in condition, with changes in level of consciousness and vital signs, for 1 of 2 residents who died and were reviewed for the prevention of death (Resident #116). Findings include: Resident #116's record was reviewed on 10/16/2012 at 2:22 P.M. Resident #16 was admitted to this facility on 6/13/2012. Resident #116's diagnoses included, but were not limited to, diabetes, uncomplicated, #16 was admitisted to form the prevention of diabetes, uncomplicated, #16 no longer resides	11/04/2012
type II, acute cerebral vascular at the facility.2. How will you disease (stroke), hemiplegia, identify other residents having the	
depression, history of acute renal potential to be affected by these	
failure, history of prostate cancer same deficient practicies and	
insitu, history of metabolic acidosis	
discrete and less and less and respective	
I I I I I I I I I I I I I I I I I I I	
Resident #116 had been in another licensed nurses were inserviced by the Clinical Nurse Specialist on	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155149	B. WIN			10/18/	2012
NAME OF A	DROLUBER OR GURRU IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	· ·		8181 H	ARCOURT RD		
	JRT TERRACE NU	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	1	<u> </u>		TAG	DEFICIENCY)		DATE
		y of 2012. This stroke			physician notification, change condition assessment, utilizing		
	_	ght side of his body.			SBAR prior to sending residen		
		cility he developed			to the hospital, utilizing vital sign		
	complications	and was sent to an			assessment methods, and	5	
	acute care hos	spital due to a mental			utilizing facility electronic medi	ical	
	status change	and was treated for			record reports to give shift to s		
	metabolic acid	osis and acute renal			report.3. What measures will		
	failure seconda	ary to volume depletion.			put into place or what systemic changes you will make to ensu		
		transfer report dated			that the deficient practice does		
		cated both issues were			not recur?Charge Nurses will		
		the course of the			notify the physician/family of a	ny	
		nd Resident #116 was			changes in condition 24 hours	a	
		Harcourt Terrace in			day/7 days per week. All licens		
					nurses were inserviced by the		
		n on 6/13/2012 to			Clinical Nurse Specialist on		
		pilitation from the			October 31, 2012, regarding physician notification, change	of	
	stroke.				condition assessment, utilizing		
					SBAR prior to sending residen		
	i i	rapy (ST) note dated			to the hospital, utilizing vital sign		
	6/14/2012 indi	cated Resident #116's			assessment methods, and		
	goal was to co	mplete self-care and			utilizing facility electronic medi		
	activities of da	ily living (ADLs) with			record reports to give shift to s		
	minimal assista	ance within the home in			report DNS/Designee will mor physician orders for physician		
	order to return	home safely with his			family notification.	anu	
		ehabilitation potential			DNS/Designee will monitor the	9	
	-	to he was independent			facility electronic medical reco		
	_	es of daily living and			facility activity report to ensure	all	
	l '	nis improving medical			resident change of condition a		
		hysical Therapy (PT)			potential change of conditions		
					reported to physician and fami		
	1	mary dated 7/6/2012			including vital signs out of rang Licensed staff not adhering to	y c .	
		rognosis for further			policy will receive education,		
		good. A Speech			disciplinary action up to and		
		note dated 7/5/2012			including termination.4. How	will	
		dent #116's prognosis			the corrective action(s) be		
	for further prog	ress was good due to			monitored to ensure the deficie		
	the strong sup	port of his significant			practice will not recur, ie, what	İ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	
		155149	B. WIN	NG		10/18/	2012
NAME OF E	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
While of TROVIDER OR SOTTELER				8181 H	ARCOURT RD		
HARCOURT TERRACE NURSING AND REHABILITATION				INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	•	l b a	DATE
	held with Resid IDT (interdiscip this meeting Rewas informed of made in therap accomplish. Rewald indicated in this her husband here husband here	ce Note dated cated a meeting was dent #116, his wife, and plinary team). During esident #116's wife of the progress being by and the goals still to esident #116's wife is meeting she wanted ome even if he was adependent. She was tiring to care for her			quality assurance program will put into place?The physician notification CQI tool will be use weekly x 4, bimonthly x 2, and quarterly thereafter, for at leas months. Action plans will be adjusted until 95% compliance achieved.5. Date of compliance 11-4-12	ed et 6	
	indicated Resident and oriented, but related to dysput dated 6/14/201 #116 was alert noted dated 7/4 Resident #116 environment, au wheelchair, was	dated 6/13/2012 dent #116 was alert out hard to understand whagia, A nursing note 12 indicated Resident 15 to self only. A nurse's 14/2012 indicated 15 was alert to self and 16 imbulated by 16 as able to make needs 18 in a happy mood that					
	Resident #116 support from fa visited almost of Discharge plan	ted 6/20/2012 indicated was a full code, had amily, and his wife daily since admission. as were for him to ith his wife. Resident					

[X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155149	B. WING		10/18/2012		
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
HARCOURT TERRACE NURSING AND REHABILITATION				HARCOURT RD NAPOLIS, IN 46260			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
TAG		<u> </u>	TAG	DLI ICILICE I	DATE		
	#116 had chosen to have life sustaining measures with approaches						
	_	o call the emergency					
		needed and notify MD					
		condition changes.					
		and the straing of					
	A nurse's note	dated 7/7/2012 at 2:15					
		, "Resident is less					
		n normal. BP (blood					
	pressure) 90/6	2 P (pulse) 64 02 sat					
	(oxygen satura	ation) on RA (room air)					
	93% Resp (res	spirations) 26. No signs					
		Opens eyes when nae					
		Answering service for					
	,	called at this time.					
	_	n call from (Nurse					
	Practitioner [N	P] named)."					
	A telephone or	der dated 7/7/12 at					
	•	cated the NP gave					
		k Resident #116's vitals					
		for 24 hours. This order					
		roblem was a change					
	in LOC (level o	of conscience) and the					
	intervention wa	as the above order.					
		nursing notes were					
		te entries on 7/8/2012					
	at 2:46 P.M. and 2:53 P.M. The late						
	,	on 7/8/2012 at 2:46					
		012 at 3:34 P.M.					
	indicated, "Resident is responding to						
		h. He is pulling hand					
		." The late entry dated					
	1/8/2012 at 2:5	53 P.M. for 7/7/2012 at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/18/2012	
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	1
	ROVIDER OR SUPPLIER		8181 H	ARCOURT RD	
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION	INDIAN	IAPOLIS, IN 46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
PREFIX TAG	7:52 P.M. indices ome juice to decoperative at WNL (within not respirations untime." The vitals reconformation of the next nursing at 12:00 A.M. in asleep with HC elevated. no see symptoms) of conted. respiration of the next nursing at 12:00 A.M. in asleep with HC elevated. no see symptoms of conted. respiration of the next nursing at 12:00 A.M. in asleep with HC elevated. no see symptoms of conted. respiration of the next nursing at 12:00 A.M. in asleep with HC elevated. no see symptoms of conted. respiration of the next nursing at 12:00 A.M. in asleep with HC elevated. no see symptoms of conted. The next nursing at 12:00 A.M. in asleep with HC elevated. The next nursing at 12:0	ated, "Resident has lrink, he is a little more this time VS (vitals) are ormal limits), labored, resting at this and indicated on 19 P.M. Resident ere: blood pressure 72, respirations 20, and ions were 96%. In g note dated 7/8/2012 and ions were 96%. In g note dated 7/8/2012 and ions were 96%. In g note dated 7/8/2012 and ions were 96%. In g note dated 7/8/2012 and ions were 96%. In g note dated 7/8/2012 and ions were 96%. In g note dated 7/8/2012 and ions were 96%. In g note dated 7/8/2012 and ions were 96%. In g note dated 7/8/2012 and ions were 96%. In g note dated 7/8/2012 and ions were 96%. In g note dated 7/8/2012 and ions were 96%. In g note dated 7/8/2012 and ions were 96%.	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
	saturation was	documented, no pulse			
		ed. According to the			
		t, the facility utilizes ranges for blood			
	pressure of 90-	•			
	•				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		A. BUILI	DING	00	COMPL		
		155149	B. WING	_		10/18/	2012
NAME OF PROVIDER OR SUPPLIER					ADCOUDT DD		
HARCOURT TERRACE NURSING AND REHABILITATION					ARCOURT RD APOLIS, IN 46260		
(X4) ID				ID I	7.11 02.10, 114 102.00		(7/5)
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRIDENCY) DEFICIENCY)		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	DATE	
	The next vitals	documented were at					
	2:15 A.M. puls	e was 48, blood sugar					
	_	, and temperature was					
		saturation or blood					
	pressure were	not documented.					
	T b	In make over 1000					
		s's note was dated					
		8 A.M. This note					
	-	in bed with HOB (Certified Nursing					
		orted res breathing with					
		went in to assess res					
	•	ations 22-24 per min.					
	` '	2 mg/DL, writer put res					
	on 2 L (Liters)	oxygen per nursing					
	measures. MD	notified writer					
	awaiting return	call. upon awaiting					
		MD writer unable to					
	•	on no chest movement					
		bed et placed on hard					
	surface CPR in	•					
	_	staff 911 called. after					
	EMT (Emerger	rrives et continued					
	•	ed on-call manager to					
		atus. family/wife					
	•	ly states they are on					
		ity spoke with (NP					
	-	amed) on call and order					
	to release body	to mortuary of choice,					
	death certificat	e completed et given to					
		rom (hospital named)					
	_	me of death per EMT					
	personnel."						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVE COMPLETED 10/18/2012	Y		
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			8181 H	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	O BE COMI	(X5) PLETION ATE		
	2:20 P.M., the clinical nurse of provide the resincluding doctor notification, carevent charting, documents, prodocumentation information regressident #116 abnormal blood on 7/7/2012 at A.M. when his as 48 beats percardiac arrest. During an interest 2:51 P.M., the clinical nurse of doctor had not abnormal blood Documentation that time or an was not available During an interest 10:06 A.M., the of Resident #1 consciousness order to monitor for 24 hours, we expectations of expected the next inclinical consciousness order to monitor for 24 hours, we expected the next inclinical consciousness order to monitor for 24 hours, we expected the next inclinical consciousness order to monitor for 24 hours, we expected the next inclinical consciousness order to monitor for 24 hours, we expected the next inclinical consciousness or the provided that the consciousness or the consci	of vitals, and any parding care given to when the first d pressure was noted 7:49 P.M. through 2:15 pulse was documented in minute prior to his view on 10/17/2012 at facility's corporate consultant indicated the been notified of the dipressure. In of a pulse taken at oxygen saturation level pole. In other with the prior to his view on 10/18/2012 at expect to the pressure of a pulse taken at oxygen saturation level pole. In other with the prior to his view on 10/18/2012 at expect to the prior to the prior to his view on 10/18/2012 at expect to the prior vitals every 4 hours was questioned of her						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION 00	COMP	E SURVEY PLETED	
		155149	B. WING			3/2012
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			8181	ET ADDRESS, CITY, STATE, ZIP COL HARCOURT RD	E	
	1			ANAPOLIS, IN 46260		_
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	sats, and if it is neurological or She indicated remember the was told. Who would have in been notified or blood pressure at 7:49 P.M. to she replied, "It talking with now would have or depended on was not, I would have certificate lister as: a. stroke dessential hypermellitus type I Cause of deat cancer localization indicated an and During an interpolation of the I (DON) reviews surrounding R The DON indicated and I in the DON in	· · · · · · · · · · · · · · · · · · ·				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	expected the r not feel oxyger necessary vita should have be doctor should the abnormal be was not docum status at the till vitals, but if the monitored for a status, the DO maybe not neu- least mental st would be expe- indicated none documented of time in questio	vitals he would have furse to obtain. He did in saturation was a life indicated a pulse gen taken and the nave been notified of plood pressure. There inentation of a mental me of the abnormal eresident was being a change in mental N indicated "then prological checks but at atus assessments cted." The ED of the staff who in this resident at the in were still employed, vailable for interviews.			

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